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ABSTRACT

This newsletter includes 12 brief articles or news items concerning mental health among minority groups. These address: (1) cultural considerations in treating Asians (reasons why Asians tend not to use mental health services); (2) coping with racial stress (responses to a questionnaire on dealing with racial stress); (3) minority health perspectives (demographic projections and research needs); (4) empowering psychologists of color (efforts to recruit and train more psychologists of color); (5) increasing public awareness of depression (the D/ART (Depression Awareness, Recognition and Treatment Campaign); (6) dealing with violent death (a personal narrative by a Japanese American whose African American boyfriend was killed by gun violence); (7) what it really takes to improve cultural competency (an interview with Juan Ramos of the National Institute of Mental Health); (8) mental health and minority seniors (a description of a brochure on this topic); (9) mental health research centers (descriptions of three centers); (10) the help-seeking behavior of minorities (comments of four experts and sources of mental health journals); (11) a new grant received by an Indiana affiliate of the National Mental Health Association which focuses on improving mental health services to Hispanics; and (12) the National Institute of Mental Health anxiety disorders program. Also included is a list of organizational resources and a message from Clay Simpson, Deputy Assistant Secretary for Minority Health. (DB)

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ED 460 456

SEPTEMBER 1997 A Newsletter from the Office of Minority Health

CLOSING THE GAP

● Office of Minority Health ● Public Health Service ● U.S. Department of Health and Human Services ●

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Mental Health and Minorities

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Cultural Considerations in Treating Asians

Study after study has shown that Asians underutilize mental health services much more than other populations, according to Stanley Sue, PhD, director of the National Research Center on Asian American Mental Health in Davis, California.

It's a trend that Dr. Sue discovered in the seventies when he was a graduate student intern at the University of California, Los Angeles Psychiatry Clinic. The clinic assessed information on the number of Asian student clients, as well as therapists' impressions of those clients.

"Not only did we find that Asians underutilized services," Dr. Sue said. "We also found that the Asian students exhibited more severe mental disturbances than the non-Asian students."

The same patterns can be seen today. The National Research Center evaluated records of thousands of clients of the Los Angeles County mental health system for a six-year period. "What we found," said Dr. Sue, "was that Asians were underrepresented in the outpatient system, and they were more likely than African Americans, Whites, and Hispanics to have psychotic disorders."

Contrary to popular belief, the fact that a certain population is not using mental health services does not indicate that the population is free of mental health problems, Dr. Sue added.

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A key question then is why? Why aren't Asians seeking and receiving treatment from state services if their mental health needs are so significant? Several factors play into why people use or don't use mental health services, including the ease of accessing services and willingness to seek help. According to experts, culture is at the heart of such factors.

"For example, in traditional Chinese culture, many diseases are attributed to an imbalance of cosmic forces--yin and yang," Dr. Sue explained. "So the goal is to restore the balance, and that might be accomplished through exercise or diet," and not necessarily through a mainstream mental health system.

While there are cultural attitudes that can be seen across the Asian population, there are important differences between groups, according to Deborah S. Lee, CSW, director of Asian American Mental Health Services in New York City.

"For all Asian groups, there is a stigma attached to going to an outsider to obtain treatment for mental health problems," Ms. Lee said. "But depending on the group, the stigma is expressed differently." This also can depend on educational background and how long a person has been in this country.

Ms. Lee's Chinese clients often interpret mental illness as punishment for some wrongdoing carried out by themselves, by their family members, or by their ancestors. For this reason, they may feel ashamed to seek or participate in treatment.

People in the Chinese community often call Ms. Lee's clinic to say they have a friend who is experiencing some problems. After telling the caller to bring in the friend, she frequently discovers that the friend is really a relative of the person who called. "The caller was simply ashamed of having such problems in the family," she said.

For Asians, the individual is commonly viewed as a reflection of the entire family. "That's why the family should be included in treatment," Lee suggests.

In the case of a Cambodian woman who suffers from depression, her husband is against her receiving treatment from Lee's clinic. "He believes she has mental health problems because she is haunted by evil spirits," Ms. Lee said. "So we had to work on convincing him to keep letting us treat her here, while they also use cultural practices at home to ward off bad spirits. We had to let him know that we could include him in the process of developing a treatment plan for his wife. We also had to make sure that each practice would not interfere with the other."

Ms. Lee finds that because the Korean community is very religious, her Korean clients often confuse their hallucinations with spiritual voices. "Our Korean clients also rely very heavily on treating themselves with medication. We have to educate them and their families about the dangers of misusing drugs and the importance of understanding that treatment for mental health problems involves more than just medication." Lee also treats Japanese clients, who are very concerned about who knows that they are in treatment. Many people have failed to show up for appointments for fear of being seen. "Sometimes, we block in an extra 15 minutes between appointment so that there is less of a chance that people might run into someone they know," Lee noted.

Asian American Mental Health Services, a state-licensed program, is specifically designed for the New York Asian community. The program operates a Chinese unit, which has a continuing treatment program for patients who are chronically mentally ill. There is also a Japanese unit, a Korean unit, and a Southeast Asian unit, all with outpatient clinics.

Ms. Lee and her staff are Asian, and they possess specialized knowledge and skills about delivering mental health services to Asians. They know, for instance, that when a client comes in complaining of an inability to move a part of the body, it's important to conduct a culturally-sensitive psychological evaluation, rather that automatically sending the client away for a physical check-up. "It's very common among Asians," Ms. Lee said, "to report physical problems that are really a reflection of mental or emotional problems."

But what about those mainstream clinics that don't have insight into Asian culture? How can services be reorganized so that Asians can be treated there? According to Dr. Sue, mental health workers need to be trained on aspects of Asian culture, and mainstream facilities should make use of Asian consultants.

"Another valuable strategy," he added, "is targeting Asians through community education." It is possible to modify attitudes this way. Important points to make are that talking with others about problems can help, that early identification is crucial, and that providers are required to keep problems confidential.

-Michelle Meadows

Coping With Racial Stress

In comparison with Whites, African Americans use more coping strategies for dealing with racial stress and engage in more planful problem solving, according to a study published in the Journal of Black Psychology.

In an effort to evaluate patterns of coping in racially stressful situations, researchers at Cleveland State University studied the responses of Whites and African Americans.

Respondents filled out a 66-item "Ways of Coping Questionnaire" and were asked to write a description of the stressful event they had in mind when filling in their answers.

Researchers note that the definition of racial stress is influenced by individual factors. Being the only one in a classroom of another race, for example, could be racially stressful to some and not others.

The African American subjects reported more incidents of racial stress than Whites due to more frequent experiences with discrimination.

Further, when experiencing racial stress, both Blacks and Whites noted a reduction in the ability to solve problems and seek social support. This difficulty was found to be particularly pronounced for Whites, the authors state. This might be, they explain, because Whites have fewer problem-solving skills in this area.

Both groups exhibited coping patterns different from those they used for stress not related to race. The researchers concluded that in order for all races to function in a multicultural society, there should be more emphasis on helping people of all races enhance coping skills.

Minority Health Perspective

Culture and Mental Health

by Delores Perone, PhD
Associate Director for Special Populations
National Institute of Mental Health

Demographers suggest that by the year 2050, half of the U.S. population will be of Hispanic, African

American, Indian, or Asian descent. And as the general population becomes more culturally diverse, the incidence of mental disorders among individuals from diverse racial and ethnic groups will also increase.

Clinicians trained in traditional, Western biomedical psychiatry and other mental health professions will face new challenges in evaluating these individuals. This fact alone demands that our scientific understanding of social and psychological functioning and mental disorders must be based on knowledge of these varied groups.

The National Institute of Mental Health (NIMH) has been the primary source of support for research to more accurately describe the nature and prevalence of mental disorders among racial and ethnic minorities, and to improve both the accuracy of diagnosis and quality of mental health services.

One outcome of research supported by NIMH has been compelling evidence regarding ways in which the varied cultural backgrounds of individuals affect the context and content of both normal and abnormal behavior, the expression of symptoms associated with particular mental disorders, and the process of conducting a diagnostic evaluation. These results have been the scientific underpinning for important work on improving the outcome of the diagnostic process for individuals from diverse backgrounds.

NIMH and the American Psychiatric Association have collaborated to enhance the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition or DSM-IV, to ensure the cultural validity and sensitivity of the diagnostic system. DSM-IV includes three types of information specifically related to cultural considerations: 1) discussion of cultural variations in clinical presentations of disorders included in the DSM-IV Classification, 2) description of culture-bound syndromes, and 3) outline for "cultural formation," an innovative approach that allows clinicians to describe the nature and extent of psychopathogy from the perspective of the patient's personal experience and social and cultural reference group.The inclusion of this information is expected to promote clinician sensitivity to the relevance of culture and racial and ethnic minority status to psychiatric assessment and the concept of comprehensive treatment.

Empowering Psychologists of Color

by Bertha G. Holliday, PhD
Director, Office of Ethnic Minority Affairs
American Psychological Association

The U.S Census Bureau is quite unequivocal: Soon after the middle of the 21st century, the majority of the nation's population will be people of color. In recognition of the numerous implications this future holds for behavioral and health research and services, the American Psychological Association's (APA) Office of Ethnic Minority Affairs (OEMA) seeks to empower psychologists of color.

The office does this by advancing the scientific understanding of culture and ethnicity relative to health and behavior; promoting the development of culturally appropriate models for the delivery of behavioral and psychological services; developing strategies for increasing the number of ethnic minority psychologists; and ensuring that the perspectives of psychologists of color influence the association's activities and policies.

OEMA has been coordinating APA's 1997 Miniconvention and National Conversation on "Psychology and Racism" (August 15-19, 1997 in Chicago). This project will highlight the growing body of psychological rsearch on racism--especially as reflected in the behavior of institutions and their effects on group differences in access to resources required by healthy people and communities.

Issues related to the need for increased numbers of psychologists of color are addressed in *Visions and Transformations: The Final Report*, which was drafted by the association's 15-member blue-ribbon Commission on Ethnic Minority Recruitment, Retention, and Training. The report describes the

troubling disparity between the current representation of psychologists of color (about 5 to 6% of all psychologists) and the nation's rapidly changing demographics. Additionally, the report identifies strategies for ethnic minority recruitment, retention, and training, and provides a five-year plan to guide APA's efforts in this area.

APA has received a major National Institute of General Medical Sciences grant to support a systematic approach to minority recruitment and retention through the establishment of five Regional Centers of Excellence in Minority Recruitment and Retention, each consisting of psychology departments at a major research university and two predominantly minority two-year and four-year institutions. *For more information, contact OEMA at 202-336-6029. E-mail: bgh.apa.@email.apa.org.*

Increasing Public Awareness of Depression: The D/ART Program

Each of us will experience ups and downs in our lives. But for some people, the down times last longer than the up times, and are severe in nature--beyond the point of what's considered healthy.

"In the United States, more than 17 million adults, or 10 percent of the population, suffer from depression each year," according to Denise Juliano-Bult, director of program and community development for the National Institute of Mental Health's (NIMH) DEPRESSION Awareness, Recognition and Treatment (D/ART) Campaign.

"Clinical depression, which affects mood, mind, body, and behavior, affects all ages, socioeconomic groups, and races," Ms. Juliano-Bult said. Depressive symptoms include sleep disturbances, sad or empty feelings, and fatigue. While the rates of depression between African Americans and Whites are similar, African Americans may have a higher rate of depressive symptoms than Whites.

Depression can be caused by genetic and biochemical factors, as well as environmental stressors and other psychosocial factors. The syndrome includes a combination of physiological, affective, and cognitive manifestations.

NIMH recognized the widespread problem of depression over 10 years ago and has been addressing it since then through the D/ART Program. The program is a national public and professional education effort that is based on 50 years of medical research and aims to reduce the personal and economic cost of depression through early recognition and treatment.

The three major components of the program are the Public Education Campaign, the Professional Training Program, and the National Worksite Program.

The Public Education Campaign uses media activities, print materials, and joint activities with D/ART Community Partners and other organizations to educate the public about depression and improve help-seeking behavior.

The Professional Training Program provides mental health providers and other professionals with up-to-date information on the diagnosis and treatment of depression. To carry out this mission, the program administers grants to universities and medical schools, and collaborates with professional associations.

The National Worksite Program educates corporate executives, managers, health professionals, other employees, and families about depression. This component of the D/ART program is implemented in

partnership with private employers and the Washington Business Group on Health. Through its three programs, "the D/ART program targets mental health professionals; gatekeepers--those who identify people with depression and make referrals such as high school counselors and pastors; primary care physicians, substance abuse counselors, older adults, and minority populations," said Ms. Juliano-Bult.

"While there are no methods of treatment specific to minorities, the D/ART program advocates that mental health professionals be sensitive to the cultural factors relevant to their client population(s)," Ms. Juliano-Bult said.

It is also important, she added, that people recognize how depression can relate to other illnesses. The rate of major depression among those with medical illness is significant. In primary care, depression rates range from five to 10 percent, and among medical inpatients, the rate is 10 to 14 percent.

Research has shown that depressive illness occurs in 40 to 65 percent of patients who have suffered a heart attack. And the depressed patients may have a shorter life span than those patients without depression. Additionally, about 25 percent of cancer patients and 10-27 percent of post-stroke patients suffer from depression. Evidence has shown that when depression is treated along with the medical illness, the medical problem is likely to improve sooner.

For free brochures on depression in English and Spanish, call the D/ART program, 1-800-421-4211.

-Jean Oxendine

DEPRESSION: DIAGNOSIS & TREATMENT

According to the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV), the criteria for diagnosis of depression are: changes in appetite and weight; disturbed sleep; motor agitation or retardation; fatigue and loss of energy; depressed or irritable mood; loss of interest or pleasure in usual activities; feelings of worthlessness or excessive guilt; suicidal thinking or attempts; and difficulty with thinking or concentration. The three types of depressive illness are Major Depression, Manic-Depressive (Bipolar) Illness, where one experiences high and low cycles, and Dysthymia, which involves similar symptoms to major depression, but the symptoms are milder and last longer. Depression is a treatable illness, with the most common methods of treatment being antidepressant medication, psychotherapy, or a combination of the two. Another treatment method, electroconvulsive therapy, is controversial. However, research has shown that there are times when it is medically justified and can save lives, according to NIMH. For those who suffer from Seasonal Affective Disorder and experience depression during a certain season (usually winter), phototherapy (light therapy) can be useful.

Dealing with Violent Death

By Tallie Kawahara, 24, Inglewood, California.
*Tallie is Japanese American. Her boyfriend, who was killed by gun violence, was African American.

It happened two weeks after my 20th birthday. The phone rang at 3:00 in the morning, and it was my friend telling me that my boyfriend, Adrian, was dead. I didn't believe it. I couldn't believe it. I called his mother and told her what I had heard, and she called the police. They told her they couldn't give out any information over the phone, and that we should come down to the station. Then I started to panic.

I was shaking so badly I could barely drive. All I kept thinking was that he was fine. Everything was fine. I told myself that he was in the hospital and I had to get there so he wouldn't be lonely. I arrived at the police station and had to wait. Finally, a police officer pulled me aside. He told me there had been a shooting outside of a club on Sunset Boulevard. Two guys--my boyfriend and his friend--were shot and both were dead. I later heard that the incident was racially motivated, but we still don't know exactly what happened. I told the officer that it had to be a mistake. Maybe it was another guy and the police were all wrong.

But it really was Adrian who was killed. I knew it the moment I saw his whole family rush into the police station. At that instant, I felt like my whole life had changed in one second. I was totally lost. I made my way back to my apartment, and a friend came to pick me up. I had been with Adrian earlier that night, but then I left to go see a movie. I kept asking myself: Why didn't I make him go with me?

I had been so in control of my life. But all of a sudden, everything seemed out of control. People told me to see a therapist. But I couldn't bring myself to see one. I felt that this was so private, and it didn't seem right to talk to a stranger. A close friend helped a lot. Unlike other people, she never once told me to get over it and move on. It doesn't work like that. It's not that simple. I also met a man whose wife and daughter had died. He had been through loss, so everything he said made sense.

I ended up moving in with Adrian's mother. We needed each other. I'm not sure what I would have done without her. I didn't go out or do much of anything for six months. And I couldn't go back to work for a month-and-a-half. Eating was hard. Sleeping was hard. Everything that I used to do so easily became hard. I was frozen. After the shooting, they opened the club right away. They just washed Adrian's blood off the pavement and kept on moving as if nothing had happened. I felt like everyone and everything was moving except for me.

They say you go through stages when someone dies. It's true. I know I went through all of them, and in a way, I still go through them. I'm sad because Adrian was only 23 when he was killed and he doesn't have a life. I'm angry at the justice system because nobody was ever held accountable for his murder.

It's a lot of mixed feelings. Part of me wants to forget that this ever happened, but another part of me needs to remember. One day, I found an old tape from my answering machine. It was Adrian's voice. Sometimes finding things like that can bring joy. Other times it can set me back.

No matter how hopeless things seemed after the shooting, I felt determined that I wouldn't turn to alcohol or drugs. I could see the temptation though. All you want to do is find a way to escape and forget what happened. I buried myself in work to help me through it.

I'm not the same person I was before Adrian was killed. I'm angrier, and I feel older than I really am. But I am dealing with the loss. I had to work through my feelings at my own pace. Looking back on those six months after the shooting when I couldn't function well, I know I needed that time in my life to be miserable.

Time has gone by, and I'm moving on now because I have to. But Adrian's death will never leave me. I'm going to be dealing with this for the rest of my life.

as told to

-Michelle Meadows

What it *Really* Takes to Improve Cultural Competency

Interview with Juan Ramos, PhD, Associate Director for Prevention, National Institute of Mental Health (NIMH)

Q. There is a lot of talk out there about how important it is to encourage mental health professionals to learn about treating diverse populations. Is this enough?

A. The encouragement is certainly important, but it is not enough. It places responsibility solely on the individual. It is more important to look at the infrastructure and authorizing bodies that impact the delivery system. It is vital that mental health facilities, educational institutions, and accrediting and licensing bodies incorporate cultural competency in their standards, criteria, and requirements.

Q. Do you think that such authorizing bodies are moving toward cultural competency requirements?

A. Not really. I have seen a lot of resistance in this area. It is true that organizations are giving increasing recognition to the importance of developing multicultural services. For example, the American Psychiatric Association has included information to enhance the cultural validity of the Diagnostic and Statistical Manual (DSM-IV) as a result of work done by an NIMH work group on culture, diagnosis, and care. The manual stresses that a clinician who is unfamiliar with a patient's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture. While addressing cultural competency this way is a step in the right direction, it's not a serious enough move toward actually requiring psychiatrists to know aspects of cultural competency. Licensing examinations do not include questions on cultural competency, so those in the helping profession cannot claim cultural competency when they successfully pass their licensing exams.

Q. What about educational institutions that offer courses on cultural competency? Are they on the right track?

A. They're on the right track, but we run into problems when that individual begins practicing in a mental health system that is not aware of cultural differences. The clinic may have set rules of treatment, and so what the practitioner learned in school might not be accepted or allowed. This is why culture needs to also be incorporated into the clinic's treatment programs. This can be done as part of meeting accreditation standards that require cultural and linguistic competency.

Q. What are the main steps that need to be taken to create real change and

make cultural competency in mental health a reality?

A. Change is always a hard thing to come by, but there must be a systematic effort that's based on accountability. The main steps are incorporating cultural and linguistic requirements in the criteria for accreditation of mental health organizations, agencies, and professional training programs, and in the factors in assessment or diagnostic tools, as well as in questions in national and state exams for licensing or certifying mental health professionals.

Q. What is NIMH doing to make these changes happen, and what can we do to help?

A. NIMH is developing the body of knowledge that will inform and improve diagnosis, treatment, and services. The Institute provides resources for the training of researchers in this area. Funded minority research centers are contributing to this knowledge base. Other agencies are applying knowledge and in the process raise pertinent research questions. We need to hear from the helping professions about research questions and relevant issues criticalfor behavioral interactions that are culturally appropriate.

Q. What are some examples of the organizations that should be making these changes--organizations that establish standards and render accreditation decisions?

A. The Joint Commission on Accreditation of Health Care Organizations (JCAHO); the Health Care Financing Administration (HCFA); the Council on Recognition of Postsecondary Accreditation (CORPA); and the Council on Accreditation of Services for Families and Children (COA). Changes are also necessary in national and state exams for the helping professions such as the Licensed Clinical Social Work Examination.

-Interview by Jean Oxendine

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has more than 500 compliance standards that organizations must meet in order to achieve accreditation. There is no standard that specifically addresses race and ethnicity, but there is an area titled "Patient Rights and Organizational Ethics," according to Janet McIntyre of JCAHO's Communications Department. One question under this area is "Are the patients treated as individuals with unique personal and health needs?" Donna Nowakowski of JCAHO's Government Relations Department said that the organization has been considering patient's rights in regards to culture, language, and religious beliefs for years. A knowledge of cultural diversity must be part of the health care organization's psychosocial assessment. Ms Nowakowski said. "We go above and beyond other reviewers in the area of cultural consideration, and this is very important to us. We push the industry to be cognizant of individual needs of patients."

Mental Health and Minority Seniors

What makes you feel sad? Who do you usually talk to if you have a problem? In your opinion, what are mental health problems?

Interviewers posed these and other questions to African Americans, Hispanics, American Indians, and Asians across the country. The interviews were conducted during a series of focus groups sponsored by the American Association of Retired Persons (AARP).

On an ongoing basis AARP works to incorporate minorities in its programs, but the focus group project marked the first time AARP set out to specifically address minority seniors and mental health, according to Betty Davis, senior program specialist in the Program Services Department at AARP.

"The purpose was to explore how older people from different racial and ethnic backgrounds feel about themselves, deal with their unhappiness, and use mental health services," Ms. Davis said.

Results from the focus group are summarized in an AARP brochure entitled Mental Health Issues for Minority Seniors: Information for Service Providers and Professionals.Two divisions within AARP--the Office of Minority Affairs and the Social Outreach and Support Section--jointly developed the brochure.

The brochure contains sections on each of the target groups. In the area of coping responses, turning to God was important for all four populations. But whereas Native Americans reported frequently talking to a priest about problems, African Americans were more divided in their willingness to talk to priests or ministers about personal problems. One reason cited was concern about whether problems would be kept confidential.

Definitions of mental health problems also varied by population. Hispanic participants, for example, defined mental health problems as alcohol and other drug abuse. And Filipino participants considered forgetfulness and anger to be mental health problems.

Up to 10 copies of Mental Health Issues for Minority Seniors are available free of charge. Write to AARP Fulfillment, 601 E St., NW, Washington, DC 20049. The order number is D15227.

Other AARP brochures on mental health may also be obtained by writing the address above. The following consumer brochures are available in English and Spanish:

Now Where Did I Put My Keys?, a self-help guide for understanding memory. English, D13829; Spanish, D14949.

So Many of My Friends Have Moved Away and Died, a guide to making new friends. English, D13831; Spanish, D14948.

I Wonder Who Else Can Help, questions and answers about counseling needs and resources. English, D13832; Spanish, D14946.

If Only I Knew What to Say or Do, ideas for helping a friend in crisis. English, D13830; Spanish, D14947.

Mental Health Research Centers

National Center for American Indian and Alaska Native Mental Health Research: The rates of post-traumatic stress disorder in American Indian and Alaska Native veterans are high, but there aren't appropriate mental health services available for the population, according to a study conducted by the National Center for American Indian and Alaska Native Mental Health Research. The findings revealed that the current services for American Indian veterans rank low in availability, accessibility, and acceptability, said Spero Manson, PhD, director of the center. As a result of this research, the Veterans Administration is making moves to establish new veteran centers that offer culturally sensitive mental health care. Funded by the National Institute of Mental Health (NIMH), the National Center identifies mental health problems and coordinates research projects that improve mental health services. The center is operated by the Department of Psychiatry, University of Colorado Health Sciences Center in Denver.

National Research Center on Asian American Mental Health: This center, also funded by NIMH, conducts research on various Asian groups, including Koreans, Filipinos, and Southeast Asians. The center investigates mental health problems among Asians, the rates of mental disturbance, and factors that affect utilization of health services. Researchers there conducted a study looking at whether it's better for therapists and clients to be of the same race and ethnicity. "We found that Asian clients who had Asian therapists stayed in treatment longer and were more likely to have better treatment outcomes," said Stanley Sue, PhD, director of the center. The center is located at the University of California, Davis, Department of Psychology.

African American Mental Health Research Center: The center is part of the Program for Research on Black Americans, which was established by an interdisciplinary team of social scientists. NIMH helped start the research center with the goal of studying African American mental health and evaluating the way African Americans seek help for mental illness. In 1993, the grant was expanded to study issues surrounding the mental health of children and adolescents. Also of interest to the center is the chronically mental ill in urban areas. The Program for Research on Black Americans is located at the University of Michigan, Institute for Social Research in Ann Arbor.

See "Resources" section for research center addresses and phone numbers.

The Help-Seeking Behavior of Minorities: Is it different than the help-seeking

behavior of Whites? Are there differences between minority groups? *Mental health profesionals from the OMH Resources Persons Network share some observations.*

Julia Mayo, PhD
Chief, Clinical Studies
Department of Psychiatry
St. Vincent's Hospital and
Medical Center
New York, NY

"Each racial and ethnic group has its own way of dealing with the mental health system. I've found that in comparison with Whites, Blacks tend to wait until they're in a crisis situation. Depression, anxiety, and phobias are not frequently diagnosed until it's very late. So Blacks often end up using emergency services and have a high likelihood of needing hospitalization. Blacks also are usually uncomfortable working with White therapists. Compared to my White patients, Blacks have been more likely to come into therapy through personal contacts. The Black patients whom I see on an outpatient basis, for example, came to me because they were referred to me by someone they knew--a friend or a family member."

Amy Okamura, MSW
Professor
School of Social Work
San Diego State
University
San Diego, CA

"Asians and Pacific Islanders don't actively seek out mental health resources. It's more culturally appropriate for them to go to a doctor with physical symptoms that are really a manifestation of mental and emotional problems. I've worked with Southeast Asians who had depression, which was expressed through headaches and sleeping difficulties. So they would seek out a physician to get relief for those symptoms. Asians and Pacific Islanders don't turn first to the Western approach of talk therapy. They might first try to change their diet, use herbal medicine, turn to acupuncture, or use a healer to rebalance their system. Fortunately, Western mental health practitioners are beginning to acknowledge the importance of these practices."

James Thompson, MD, MPH
Professor of Psychiatry

University of Maryland
Baltimore, MD

"As with any minority group, there are variations within the group. But in my experience, Native Americans are usually very pragmatic in seeking help for mental health problems; they want to find something that works. They often have a built-in distrust of the mainstream system, so they won't always seek help there. And when they do, they tend to be wary. I have also found that Native American men, more so than women, associate mental health problems with weakness, and therefore may feel ashamed of seeking help."

Jaime Trujillo, MD Chairperson,
Adolescent Division
Department of Psychiatry
Cook County Hospital
Chicago, IL

"In my experience, Hispanics have a lot of denial. They don't seek care for mental health problems, but rather for physical symptoms that are related to those problems. They also wait until the last minute to get help. Hispanics with limited English skills are often very afraid that they can't communicate well. So they don't seek mainstream mental health services for fear of being misunderstood. There are also distinct differences within the Hispanic population in regard to attitudes about mental health services. For example, many Cubans exhibit similar attitudes to Whites in that they are more likely to get help early. And Puerto Ricans and African Americans are similar in that they are more likely to seek services from the state. Mexicans seem to be less likely to view state services as an option."

Obtaining Mental Health Journals

Cultural Diversity and Mental Health. Contact John Wiley and Sons, Subscription Dept., 605 Third Ave., New York, NY 10158, 212-850-6000.

Journal of Black Psychology; Hispanic Journal of Behavioral Sciences. Contact: Sage Publications, Customer Service Dept., PO Box 5094, Thousand Oaks, California 91359, 805-499-9774.

American Indian and Alaska Native Mental Health Research. The Journal of the National Center for American Indian and Alaska Native Mental Health Research. Contact: University Press of Colorado, PO Box 849, Niwot, Colorado 80544, 303-530-5337.

NMHA Affiliate Receives Grant to Serve Hispanics

Twenty years ago, Carmen Hansen-Rivera conducted research that revealed a low use of mental health services by Hispanics. The chief explanation was that services were not tailored to the population's needs.

Not much has changed. Ms. Hansen-Rivera carried out research that yielded the same results that surfaced years ago. "Only now it seems worse because the Hispanic population in this country is so much bigger," she said.

A Board member of the Mental Health Association Marion County, Indianapolis, Indiana, Ms. Hansen-Rivera helped convene a group of Hispanic community leaders to identify mental health needs and barr iers for this population in the county. She and her colleagues also reviewed data from state agencies to evaluate utilization rates and patterns. Many Hispanics, they discovered, were unaware of the services available to them. "And those who did know about services either didn't have access to them or didn't use them because they weren't culturally and linguistically appropriate," she said.

As a result of the findings, the United Way of Central Indiana has awarded a Targeted Initiatives Fund grant to the Marion County Mental Health Association, an affiliate of the National Mental Health Association (NMHA). The grant will support the association's efforts to provide and improve mental health services to Hispanics in the area.

"Hispanics in our county are facing a crisis situation because there have been repeated reports of severe problems with alcohol and other drug abuse," Hansen-Rivera said. "But what's happening is that people are being put in jail, and the population's mental health problems and needs are slipping through the cracks."

Finding ways to gain the trust and faith of the Hispanic community is the key to effectively delivering mental health services, she added. Since Hispanics often go to their ministers first to discuss problems, the mental health association plans to provide education to ministers. "We'll teach them how to identify signs of depression and other mental illness," Hansen-Rivera said. "And we'll train them to put people in touch with other forms of help when necessary."

The association will also use the United Way funds to conduct other "train the trainer" sessions. Hispanics will learn to present a program that will help fellow community members improve parenting skills and strengthen their families. Those trained will learn how to deliver a 15-week parent/child nurturing program for approximately 20-24 families. Additionally, the grant will allow for the development of a directory of bilingual, bicultural mental health providers in the county.

"The work in Marion County will not only educate Hispanics there about the availability of mental health services, but also empower them to seek out those services," according to Judy Leaver, vice president of affiliate services at NMHA.

"Addressing the mental health needs of minority populations is extremely important to

NMHA," Ms. Leaver said. For four years the association has partnered with other organizations on the National Public Education Campaign on Clinincal Depression. The campaign targets specific groups, including African Americans, Hispanics, older Americans, and youth. "The Delta Sigma Theta sorority has really helped to make the outreach to African Americans successful," Ms. Leaver said. "They are our eyes and ears--our link to the community."

The minority-focused projects carried out by NMHA affiliates run the gamut, Leaver added. In addition to its work with Hispanics, the Marion County affiliate has reached out to African Americans through a year-long effort called "The African American Family--Mind, Body, and Spirit." The mental health association of Alameda County, California has established a support group for African American families who have loved ones with mental illness. And the NMHA affiliate in Union County, New Jersey, is active in its efforts to educate Hispanics about recognizing and coping with anxiety disorders.

"Our affiliate activities reflect NMHA's belief that reaching diverse populations is essential to community mental health," said Ms. Leaver. "We hope to do even more in the future."

-Michelle Meadows

The NIMH Anxiety Disorders Program

We all know what it's like to feel anxious--that feeling you get right before you have to make a speech in front of a large audience, for instance.

Anxiety is a normal emotion, and it actually helps us cope with daily life. But for the more than 23 million Americans who suffer from anxiety disorders, the emotion can make coping impossible.

Rather than experiencing normal stress, people with anxiety disorders experience overwhelming anxiety and fear. They may be tormented by panic attacks, obsessive thoughts, or flashbacks.

Due to stigma and widespread lack of understanding, most people with anxiety disorders, depression, or other mental illness face great difficulty seeking appropriate treatment.

According to Steve Hyman, MD, director of the National Institute of Mental Health (NIMH), anxiety disorders are the most common mental illnesses in America. "Yet many people who have them are suffering in silence and secrecy, innappropriately ashamed or unaware of the availability of excellent treatments," he said.

The NIMH Anxiety Disorders Education Program helps people recognize and find treatment for various anxiety disorders, including obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, phobias, and generalized anxiety disorder.

"Anxiety disorders, like other mental illnesses, reflect dysfunctions within the brain," Dr. Hyman said. "We are on the path to discovering genes that make people vulnerable to

anxiety disorders. Already, the fruits of research have resulted in the development of effective treatments for millions of Americans living with these illnesses, but the promise for the future is even greater."

Through the NIMH education program, Hyman said, the institute can communicate research findings and help the public and their health care professionals recognize that these are real medical illnesses that can be effectively diagnosed and treated. Effective treatments for anxiety disorders include medication, psychotherapy, or a combination.

Strategies in the program are based upon extensive audience research involving people with anxiety disorders, their families, and health professionals, and incorporate the theme line, "Anxiety Disorders. Frightening. Real. Treatable."

NIMH conducted research through a series of focus groups. Most participants, with the exception of adult trauma victims, reported suffering from their anxiety symptoms for years before seeking help.

Many participants also reported that they saw a number of medical and mental health professionals before they were correctly diagnosed with their anxiety disorder. The most commonly reported "worst" aspect about living with undiagnosed anxiety disorders was the inability to do what one wanted in life, such as advancing in one's career, going to school, or having a "normal" social and family life. The most commonly mentioned barrier to seeking or receiving treatment in all groups was lack of medical insurance coverage.

Educational components of the program include media relations, public service announcements, partnerships with professional and voluntary organizations, worksite education, professional seminars and exhibits, an NIMH anxiety disorders Web site, and outreach to minorities and youth.

NIMH is part of the National Institutes of Health. The institute also runs the Panic Disorders Education Program and the DEPRESSION/Awareness, Recognition, and Treatment program, which together have reached millions of people.

To learn how to get involved in the Anxiety Disorders Education Program, call 301-443-4536. For information about depression, call 1-800-421-4211. For information about panic and other anxiety disorders, call 1-800-647-2642.

NIMH Develops Booklet on Panic Disorder

To raise awareness among Hispanics about how to recognize and get treatment for panic disorder, NIMH has developed a Spanish-language booklet on the subject. The illustrated publication tells the story of Monica, a young woman who struggles with the episodes of extreme terror that characterize panic disorder. Because the symptoms--pounding heartbeat, chest pain, difficulty breating, and dizziness--can mimic symptoms of other illnesses, obtaining proper diagnosis and treatment is often difficult. For a free copy, call the OMH Resource Center at 1-800-444-6472. (Pub. # 291)

Resources: Mental Health

American Psychiatric Association. 1400 K St., NW, Washington, DC 20005, 202-682-6000.

American Psychological Association. 750 First St., NE, Washington, DC 20002, 202-336-5500.

Association for the Advancement of Behavior Therapy. 305 7th Ave., New York, NY 10001, 212-647-1890.

National Alliance for the Mentally Ill. 200 N. Glebe Rd., Suite 1015, Arlington, VA 22203, 1-800-950-6264.

National Mental Health Association. 1021 Prince St., Alexandria, VA 22314, 703-684-7722.

Association of Black Psychologists. PO Box 55999, Washington, DC 20040, 202-722-0808.

Black Psychiatrists of America. PO Box 1758, North Little Rock, AR 72115, 501-661-1202.

The Center for Multicultural and Multilingual Mental Health Services. 4750 N. Sheridan Rd., Ste. 300, Chicago, IL 60640, 312-271-1073.

African American Mental Health Research Center. Institute for Social Research,

University of Michigan, 426 Thompson, Rm. 5118, Ann Arbor, MI 48106, 313-763-0045.

Research Center on the Psychobiology of Ethnicity. UCLA Medical Center, Dept. of Psychiatry, 1000 West Carson St., Torrance, CA 90509, 213-533-3188.

National Research Center on Asian American Mental Health. University of California, Davis Dept. of Psychology, Davis, CA 95616, 916-752-1400.

National Center for American Indian and Alaska Native Research. University of Colorado Health Sciences Center, Dept. of Psychiatry, 4455 East Twelfth Ave., A011-13, Denver, Colorado 80220, 303-315-9232.

Anxiety Disorders Association of America. Department A, 6000 Executive Blvd., Ste. 513, Rockville, MD 20852, 301-231-9350.

National Institute of Mental Health, National Institutes of Health. Parklawn Bldg., 5600 Fishers Lane, Rockville, MD 20857. Toll-free lines: Depression, 1-800-421-4211; Panic and other anxiety disorders, 1-800-647-2642.

Mental Health Directories

Directory of Ethnic Minority Professionals in Psychology. Contact: American Psychological Association, Order Department, 202-336-5500.

The Mental Health Addictions and Crisis Services Grant Guide is available from the Foundation Center. It provides descriptions of grants for mental health facilities, hospitals, and hotline and crisis intervention services. Contact the center at 79 Fifth Ave., New York, NY 10003, 1-800-424-9836.

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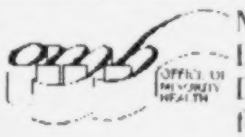

Message from Dr. Clay E. Simpson, Jr. PhD Deputy Assistant Secretary for Minority Health

I hope that each of you will increase your efforts to promote equality in health care for all Americans. The Office of Minority Health will be seeking new partners and innovative ways to deliver health information to multicultural communities.

Increasingly, minority populations are experiencing increased pressures and societal demands as they strive to cope with such issues as education, welfare reform, alien status, and managed health care. These issues are impacting all citizens in the form of increased bouts of depression, stress, and anxiety disorder. Some people have recently immigrated to the United States and may not be fluent in the English language. This can make it difficult to understand eligibility requirements for needed health services.

Many minorities are unemployed and live below the poverty level. In many cases, our constituents do not have access to health care facilities and lack health insurance. Cultural differences often cause anxieties that the majority population may not understand.

Cultural competency is an area in which OMH is working diligently. This means that OMH encourages institutions to include cross-cultural curriculum that will train health care professionals to recognize cultural differences, increase their understanding of such differences, and develop awareness that will allow them to provide culturally-appropriate treatment.

A stigma toward those suffering from mental illness still exists in our communities. Both patients and providers fail to recognize symptoms, and the condition often goes untreated. When mental illness afflicts minorities, the stigma can be coupled with cultural taboos that may further increase barriers to treatment.

Please join OMH in raising awareness of mental health issues in minority communities and bringing treatment to those who need it. Remember to use the OMH Resource Center. Our information specialists can conduct a database search on mental health, and help you obtain information on programs, organizations, and funding sources.

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Closing the Gap is published by the Office of Minority Health Resource Center, a service of OMH. If you have comments please call 1-800-444-6472, or write to OMH-RC, P.O. Box 37337, Washington, DC 20013-7337. You can also e-mail us at info@omhrc.gov.

For customized service, free of charge,
please call the Resource Center toll-free at
1-800-444-6472
to speak to trained information specialists
who will assist you with your needs.